The Interface

Borderline Personality and Externalized Aggression

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This ongoing column is dedicated to the challenging clinical interface between psychiatry and primary care—two fields that are inexorably linked.

ABSTRACT

Individuals with borderline personality disorder are diagnostically and clinically characterized by self-harm behavior, as indicated by the criterion in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision*, "recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior." However, individuals with borderline personality disorder can display externalized aggressive behavior, as well. In an area characterized by considerably less research, empirical evidence indicates that individuals with borderline personality disorder may exhibit physical violence toward partners, physical violence toward known but nonintimate individuals, criminal behaviors that embody externalized violence (e.g., property damage), and, on very rare occasion, murderous behavior (either of family members or anonymous others through serial killing). Given this under-researched area, there are probably other types of externalized aggressive behaviors that have not been empirically revealed. However, externalized aggressive behaviors in individuals with borderline personality disorder clearly exist and need to be assessed in both psychiatric and primary care settings in an effort to promote safety of medical personnel and effective patient management.

KEY WORDS

Aggression, borderline personality, criminal behavior, externalized aggression, partner violence, murder, self-harm behavior

INTRODUCTION

Borderline personality disorder (BPD) is diagnostically and clinically characterized by self-harm behavior (e.g., self-directed). In support of this impression, one of the criterion for BPD in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (*DSM-IV-TR*)[1] is, "recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior." As evidence for this criterion, Oumaya et al[2] reviewed the literature and reported that self mutilation occurs in up to 80 percent of individuals with BPD, with more than 41percent reporting 50 or more incidents. Black et al[3] found that at least three quarters of patients with BPD have attempted suicide. Zanarini et al[4] found that in an inpatient sample of 290 individuals

with BPD, 60 percent evidenced two or more past suicide attempts. While self-directed aggressive behavior by individuals with BPD is well documented, externally directed aggressive behavior is less described in the empirical literature.[5] Yet, in the *DSM-IV-TR*,[1] another diagnostic criterion for this Axis II disorder is, "inappropriate and intense anger or difficulty controlling anger" with possible "frequent displays of temper, constant anger, [or] recurrent physical fights." In this edition of The Interface, we discuss the empirical literature related to externalized aggression in individuals with BPD, including intimate partner violence, nonintimate assault, various criminal behaviors, and murder.

INTIMATE PARTNER VIOLENCE

Male perpetrators. In the empirical literature, there is reasonably good evidence for associations between BPD and partner violence. For example, Dutton and Starzomski[6] examined 75 male perpetrators of partner violence and found that BPD scores correlated with the degree of abusiveness reported by female partners. Based on a review of 79 male perpetrators, Tweed and Dutton[7,8] developed a clinical typology, which included an impulsive subgroup characterized by a mixed psychological profile with BPD elements. Porcerelli, Cogan, and Hibbard[9] asked 52 clinicians to describe a patient of theirs who was violent toward a partner; the subsequent analysis of these patient descriptions revealed that perpetrators had antisocial and borderline personality features. In a Canadian study of a cohort of 226 court-mandated male batterers, Tong[10] reported associations with BPD. Mauricio and Lopez[11] classified a cohort of male batterers with regard to level of violence. In this study, those with high-levels of violence were most distinguished by borderline personality characteristics. Finally, Ross and Babcock[12] examined male batterers in terms of patterns of violence and the relationship to general personality pathology. Proactive violence was associated with antisocial personality disorder whereas reactive violence was associated with BPD. The preceding sampling of studies indicates patent associations between BPD and male perpetrators of partner violence, suggesting that BPD is relatively common in men with externalized aggression in the form of partner violence.

Female perpetrators. Given that associations between BPD and male partner violence appear well established, there is also a small literature on BPD and female perpetrators of partner violence. Hughes et al[13] studied 103 women who were court-referred because of physical violence in their relationships; again, BPD demonstrated a correlation with increasingly violent behavior.

Hines[14] examined men and women from 67 worldwide university sites (this was an analysis of data from the International Dating Violence Study) and found that in this nonclinical sample, BPD predicted several forms of interpersonal violence. Specifically, BPD was a significant predictor of the number of types of physical, psychological, and sexual aggressive behaviors toward an intimate partner. In this study, gender was not a mediating variable.[14]

Familicide. Perpetrators of familicide (i.e., homicide of the intimate partner and at least one child) have also been studied and found to have BPD characteristics or disorder. Specifically, in a Canadian study, Lveille, Lefebvre, and Marleau[15] examined 16 cases of familicide—all perpetrators were men and many demonstrated BPD features or disorder (the original report is in French, so more specific details are inaccessible). Nearly half used excessive violence during the crime and many killed themselves after the act.[15]

Nonintimate assault. While rarely studied, there is some evidence that BPD is also associated with nonintimate assault in which the perpetrator knows the victim but not in a confidential manner. For example, during an eight-year study period, Gross examined patients in a forensic facility who assaulted either other patients or staff and studied their psychological characteristics.[16] In this study, individuals with Axis I disorders did not exhibit the aggression potential of those with Axis II disorders. At the end of the study, Gross concluded that patients with antisocial and BPD disorders had the highest frequency of assaultive behavior.

In a study of 375 consecutive internal medicine outpatients, we examined relationships between criminal charges (not necessarily convictions) for assaultive behaviors and BPD using a self-report methodology.[17] In our analyses, both simple and aggravated assault statistically significantly correlated with the two study measures of BPD.

Criminality. Criminal behavior oftentimes involves externalized aggressive behavior by the perpetrator. In a review of the literature, we found associations between BPD and criminality, particularly among incarcerated female offenders.[18] In these cases, the committed crimes were frequently impulsive and violent. In addition, Goodman and New[19]

described an association between BPD and property violence. Finally, in the previously mentioned study of internal medicine outpatients, we examined and found relationships between BPD and charges for 27 criminal behaviors (again, not necessarily convictions) as defined by the cataloguing system of the Federal Bureau of Investigation.[17] In this latter study, in addition to the previously noted relationships with assaultive behavior, participants with BPD were also more likely to be charged with disorderly conduct and public drunkenness/intoxication. Overall findings support relationships between BPD and some types of externally aggressive criminal behaviors.

Serial murder. In relationship to other types of assault, serial murder is perhaps the most shocking assaultive behavior. Unlike the previous forms of interpersonal assault, in which the perpetrator usually has some relationship to the victim, either intimate or at least familiar, with serial murder, the perpetrator typically has absolutely no relationship to the victim. Therefore, this type of seemingly random but rare crime is a particularly unique form of externalized aggression in the BPD literature, rather than the more typical reactive and explosive behavior observed in relationships with known others.

In support of this association, Papazian[20] undertook a literature review of over 160 serial killers during the past century and examined their psychological characteristics. She identified several characterological subtypes of serial killers—those with antisocial, schizoid, and borderline personality disorders.

Ansevics and Doweiko[21] studied 11 serial killers through a detailed retrospective analysis. All of these subjects had experienced a significant loss around age 5, the majority had grown up in violent homes, and murder seemed to be a "working through" process and/or an attempt to adjust to internal and external demands. The authors concluded from their investigation that serial killers do not represent a subtype of antisocial personality disorder, but rather a subtype of BPD.

Table 1 provides a summary of the different types of externalized aggression observed in BPD patients.

TABLE 1. Examples of externalized aggression in individuals with borderline personality disorder

- Intimate partner violence (both men and women)
- Nonintimate assault (i.e., assault of individuals known to the perpetrator)
- Aggressive criminal behaviors (e.g., property damage, disorderly conduct, public drunkenness/intoxication)
- Murder (e.g., familicide, serial killing)

CONCLUSION

While BPD is oftentimes associated with self-harm behavior, such as cutting, burning, or scratching oneself, individuals with this Axis II disorder may also funnel their aggression into the external environment. Externalized aggression in individuals with BPD may result in intimate partner violence, assault of those who are familiar to the individual but not intimates, various types of aggressive criminal behavior, and rarely murder in the form of familicide and serial killing. Therefore, in psychologically assessing individuals with BPD, it is important not only to examine the patient's history of self-harm, but also to explore their history of externalized aggression. This latter feature may be particularly salient in terms of anticipating future management issues, especially in inpatient psychiatric settings, which represent more psychologically disturbed individuals. Further research is warranted in this area to investigate more subtle forms of externalized aggression (e.g., breaking objects, punching walls), the presence or not of any gender patterns with specific behaviors, and the role, if any, of comorbid antisocial personality disorder. Clearly, the relationship between BPD and externalized aggression is relevant for clinicians in both psychiatric and primary care settings, and a clearer understanding of these associations will hopefully promote improved and safer patient/provider interaction.

REFERENCES

1. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision.* Washington, DC: American Psychiatric Association, 2000.
2. Oumaya M, Friedman S, Pham A, et al. Borderline personality disorder, self-mutilation, and suicide: literature review. *Encephale.* 2008;34:452-458.
3. Black DW, Blum N, Pfohl B, Hale N. Suicidal behavior in borderline personality disorder: prevalence, risk factors, prediction, and prevention. *J Pers Disord.* 2004;18:226–239.
4. Zanarini MC, Frankenburg FR, Khera GS, Bleichmar J. Treatment histories of borderline inpatients. *Compr Psychiatry.* 2001;42:144–150.
5. Alden SA. Borderline personality and aggression: exploring mediating and moderating roles of psychophysiological arousal.

Dissert Abstr Int. 2009;69:6397B.
6. Dutton DG, Starzomski AJ. Borderline personality in perpetrators of psychological and physical abuse. *Violence Vict.* 1993;8:327–337.
7. Tweed RG, Dutton DG. A comparison of impulsive and instrumental subgroups of batterers. *Violence Vict.* 1998;13:217–230.
8. Dutton DG. Personality dynamics of intimate abusiveness. *J Psychiatr Pract.* 2002;8:216–228.
9. Porcerelli JH, Cogan R, Hibbard S. Personality characteristics of partner violent men: a Q-sort approach. *J Pers Disord.* 2004;18:151–162.
10. Tong ARWC. A multivariate path model for understanding male spousal violence against women: a Canadian study. *Dissert Abstr Int.* 2004;64:5238B.
11. Mauricio AM, Lopez FG. A latent classification of male batterers. *Violence Vict.* 2009;24:419–438.
12. Ross JM, Babcock JC. Proactive and reactive violence among intimate partner violent men diagnosed with antisocial and borderline personality disorder. *J Fam Violence.* 2009;24:607–617.
13. Hughes FM, Stuart GL, Gordon KC, Moore TM. Predicting the use of aggressive conflict tactics in a sample of women arrested for domestic violence. *J Soc Pers Relat.* 2007;24:155–176.
14. Hines DA. Borderline personality traits and intimate partner aggression: an international multisite, cross-gender analysis. *Psychol Women Q.* 2008;32:290–302.
15. Lveille S, Lefebvre J, Marleau J-D. Familicide in Quebec: 1986 to 2000. *Ann Med Psychol.* 2009;167:591–596.
16. Gross J. Aggression in hospitalized criminal offenders with mental illness and personality disorders: a psychoanalytic retrospective longitudinal study. *Dissert Abstr Int.* 2007;68:621B.
17. Sansone RA, Lam C, Wiederman MW. The relationship between illegal behaviors and borderline personality symptomatology among internal medicine outpatients. *Compr Psychiatry.* 2012;53:176–180.
18. Sansone RA, Sansone LA. Borderline personality and criminality. *Psychiatry (Edgemont).* 2009;6:16–20.
19. Goodman M, New A. Impulsive aggression in borderline personality disorder. *Curr Psychiatry Rep.* 2000;2:56–61.
20. Papazian LM. Literature review on the personalities and patterns of serial killers. *Dissert Abstr Int.* 2001;61:6144B.
21. Ansevics NL, Doweiko HE. Serial murderers: early proposed developmental model and typology. *Psychother Priv Pract.* 1991;9:107–122.

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